THE "GENERAL PRACTITIONER" CONTINUES AS A VITAL FACTOR IN MEDICAL PRACTICE

Finally, let me emphasize a duty of the medical profession which seems to me of fundamental importance. It involves the general practitioner of medicine and comes to the very heart of the difference between the majority and the minority reports of the Committee on the Costs of Medical Care. Notwithstanding much loose talk about the "passing of the general practitioner," he is today the center and foundation of the practice of medicine as he has been from the ancient days of Greece, where scientific medicine had its birth. The great traditions of medicine down through the centuries gather around him and many of its finest achievements are attributable to him. Even today when specialism has developed to a high point, when laboratory aids to diagnosis and treatment are multiplied almost beyond count and when groups and clinics are bidding for patients, it still remains true that nothing can take the place of personal contact between the physician and his patient. The practice of medicine at its best must always be a personal and very intimate service. Whatever methods are devised for supplying medical care to certain special groups or to certain types of sickness or disability, it will remain permanently true that more than 90 per cent of all medical care must be furnished by the general practitioner in personal contact with the patient. Neither the group, the clinic, nor the specialist can ever take his place. He will continue to do in the future, as he has in the past, the great bulk of routine practice which takes him into every household in the land and makes him the adviser and the friend in time of need. The general practitioner is facing today more difficult problems than any other man in the medical profession. They have arisen because of revolutionary changes which have taken place both within and without the profession. The medical profession should realize that it must rise or fall with him, and the public should be made to see that whatever injures the rank and file of the doctors of the land will inevitably bring injury to the people. To make the general practitioner more efficient should be our highest ambition as members of our common profession, to save him from evil should be the constant care of all. The medical profession faces nothing more important today than the restoration of the old-time family physician to his central place in medical practice. Our fortunes are inextricably involved with his. Here is a problem which the entire profession must help to solve.

FUNDAMENTAL IDEALS AND ETHICS ARE OUR PERMANENT HERITAGE

Problems such as these we are considering today will come and go in the course of social progress, but the fundamental ideals and ethics upon which our profession is founded constitute our permanent heritage, which we must pass on to our successors. The cynic may believe the frequently repeated statement that "ethics is bunk," but the fact remains that all social progress depends upon the acceptance of ethical standards. Medical ethics to the layman, too often, unfortunately, means the efforts of doctors to protect each other and to uphold their guild. It is true that, exceptionally, a wrong may be done in this direction, but medical ethics are founded upon eternal principles of justice and right and from the ancient days of medicine have furnished the incentive for high idealism and unselfish service to mankind. We must not be led by "counsels of desperation" to permit the breaking down of the ethical standards of our profession in the name of efficiency or the lowering of costs.

IN CONCLUSION

When the problems of the costs of medical care are finally solved it is probable that the recommendations of the Committee on the Costs of Medical Care for group practice and group insurance will play some rôle, but a very minor and limited rôle, in the solution. In the meantime these methods should be developed slowly and carefully and with strict regard to fundamental principles of medical practice which have been formulated and are well known to us all. At the present moment nothing is more important within the medical profession than a solid, united front. We must stand firmly together in our national, state, and county organizations to uphold the noble traditions and the high ethical standards of our profession. We must not permit ourselves to be broken up into competing groups or brought under the domination of institutions either of our own or others' devising.

The direction in which medicine is to develop is peculiarly in our hands today. It is no time for lazy indifference or smug complacency but for energetic action and wise planning. Only the pusillanimous would counsel surrender or compromise of principles because they are under attack.

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SOME TRENDS IN MEDICAL ECONOMICS*

By R. G. LELAND, M. D.
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IN the past few decades there has been an increasing tendency on the part of business men to form "trade associations." Joint action in the business field replaces competition in many ways and more effectively where informal sentiments of coöperation are strengthened by formal organization of potential competitors. These trade associations have contributed their share toward uniformity of prices, a phase of business which has an appreciable influence upon competition.

TRADE AND PROFESSIONAL ASSOCIATIONS

In many professions, groups organized for the benefit of both the members and the public, exist. The outstanding difference between trade associations and professional associations must be constantly borne in mind. The purpose of pro-

* From the office of the director of the Bureau of Medical Economics, American Medical Association, Chicago.
* Read before first general meeting of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.

fessional association is seldom, if ever, exclusively or avowedly, to form a monopolistic agreement about price. These associations are usually not organized for or considered as business combinations. They do illustrate, however, a connection between public-spirited action and the private interests of their members.

The traditional beliefs and practices with respect to business life are exactly opposite to those with respect to the professions. One may enter business if he has sufficient money or capital with which to build his plant and market his goods, and he may continue in business as long as he can find customers willing to pay him profitable prices for his wares. It is usually contended, in defense of the aforestated attitude, that the consumer is capable of protecting his interests in traffic with business and that competition between business rivals ultimately eliminates the unfit.

WHEREIN THE MEDICAL PROFESSION DIFFERS

But this condition does not obtain in medicine. An individual may have capital enough to provide himself with the most elaborate offices and he may, by various means, be able to find persons who desire advice pertaining to health and disease, but this is not sufficient basis upon which to practice medicine. The medical profession has long recognized its prime object to be the service it can render to humanity. For the protection of the public, it holds that persons setting themselves up as doctors of medicine shall meet minimum standards of preparation and shall observe certain principles of ethical conduct. Recognition of the validity of minimum educational requirements is found in the statutes of the several states and territories regulating the practice of medicine. In the realm of business and commerce, such an arrangement is termed "restraint of trade" and is considered unfair because of the limitation it places upon free competition. In the professions, however, this "restraint of trade" is justified on the premise that it bears an intimate relationship to the public good. Those who deal with human values must, by training and conduct, be competent and dependable, hence the desirability of reasonable checks, standards, and restraints.

GROUP ACTION AND INDIVIDUAL PRACTICE IN MEDICINE

In other respects both the group action and individual conduct of physicians have differed from commercial groups. Inherited from that celebrated Greek physician of Cos, some time during the fifth century, B. C., the principles of ethics of the medical profession have set physicians apart from other groups having purely business, production, or commercial interests. It has been suggested that the medical profession has given too little consideration to some of the business phases of medicine, but by tradition, training, and experience physicians have devoted their lives primarily to human values and scientific advance and only secondarily have they considered monetary values.

To trace the rise of the present unrest over some phases of medical care, although interesting and enlightening, would require too much time for our present discussion; suffice it to say that from many quarters of the platform and press, charges have been made that it is the responsibility of the medical profession to bring forth from the present economic system a plan to provide medical services at greatly reduced cost.

The effect of our increasingly complex social and economic structure upon the practice of medicine has prompted the medical profession only recently to apply accepted methods of economic investigation to the economics of the production and distribution of medical care.

MEANING OF MEDICAL ECONOMICS

Medical economics might be described, if not defined, as that branch of economics that deals with the production, distribution, and consumption of the values involved in medical services. While medicine must function and these services must be produced in the environment largely dominated by industrial conditions, yet the typical set-up of land, labor and capital, with their respective relations to the productive and distributive processes, is practically never found in the normal relations of patients and physicians. The practice of medicine nor, for that matter of any of the professions, does not fit into the picture of general economics.

The work of the physician, lawyer, teacher, does not in any way depend upon adding "utilities" to some sort of raw material. It is not the work of the physician to change the "time, form, or place" of the human bodies with which he works, but rather to restore them to at least a supposedly original condition of health and keep them that way.

When attempt is made to introduce other economic categories into a discussion of medical services the result is only to create confusion. Studies of medical care constantly refer to the "capital investments" of the physician or to the amount of "medical capital" invested in hospitals, laboratories, etc. The subsequent reasoning falls into a mass of confusion, through the effort to carry industrial implications of capital over into the reasoning about medical practice.

THE TERM "CAPITAL"

"Capital," as the term is used in the economics of modern industry, is an investment with the expectation of a financial return, through hiring laborers and organizing and managing a financially profitable industry. Upon this use of the word has been built the elaborate theories of economics, the implications of which can only with great difficulty be disassociated from the word. It naturally follows that most of those who use this term in discussing medicine, instead of avoiding these implications accept them, and reason as if the use of the word necessarily gave these economic theories full validity in the field of medicine.

The existence of office and laboratory equipment, scientific instruments, library, automobile, telephone, etc., in which a modern physician must invest properly to conduct his practice, involves

none of the relations, functions or implications which accompany the ownership of "capital" in the industrial sense. The physician's equipment is intensely personal to him in ownership and operation, whereas it is just the complete absence of any personal relation or ownership between industrial capital and those who use it that is most characteristic of the present system of industry. Nor, as some writers have attempted to show, is the individual practicing physician in the outgrown "household stage" of industry, from which he is inevitably destined to evolve, according to the pattern of industry into the "domestic" and ultimately to the "factory" stage of mass production. He is not "producing" for his own family, nor sending out goods into a market whose inevitable growth to national, or even world extent compels him continuously to expand.

This confusion is increased when the cost of his education is added to the physician's "capital" account. There is logic in insisting that this expense be considered in determining the cost of preparation for the profession and thereby constituting an economic check on the supply of physicians, with whatever effect that will have on incomes. This is something wholly different from classifying such costs as "capital" upon which the current rate of interest must be paid if the "firm" is to continue in business.

PERSONAL CHARACTER OF THE PHYSICIAN'S INVESTMENT

It is the personal character of the physician's investment which is significant. The owner of stocks and bonds usually never sees the property to which he has title. It may be on the other side of the world. He buys or sells it with no effect, other than financial, upon his life.

The physician's investment in education and training is a vital part of his life. Its attainment and possession affords him satisfactions entirely apart from its income producing qualities. He cannot buy or sell it in any market apart from himself. If it is outgrown or rendered "obsolescent" he cannot rid himself of it by "writing it off" some balance sheet. Because it cannot be used by anyone else it lacks the characteristic quality of industrial capital—it cannot compel the labor of others.

The real medical capital, consisting of accumulated knowledge, is stored in the minds, ideals, traditions, and in the publications of the medical profession and is shared freely with the public through universities, journals, discussions, the public press, radio, and individual consultations. This capital cannot be monopolized for profit. It does not fit into the capital concept of industrial economics, yet it is the greatest asset of the profession. Without it all physical capital would be worthless.

MEDICAL EVOLUTION CHARACTERIZED BY DISCOVERIES IN SCIENCE

Alongside of the evolution of the tools with which man has produced goods for the market, of the expansion and complexity of that market and the organization of industry, there has been a corresponding but seldom similar evolution of the medical and other professions. This professional growth is not primarily characterized by the invention and development of ever more complex and labor-saving tools to produce for constantly expanding markets. The dynamic central element in medical evolution, so often traced by medical historians from the code of Hammurabi and the writing of Hippocrates to the present time, is found within the human mind, and expresses itself in scientific discoveries, in new applications of logic to facts discovered through the closer examination of the human body in health, disease, and after death. The significant feature of this evolution has been the steady addition of new found facts, and new explanations of already known facts, to a continually growing body of professional knowledge.

This widening and deepening stream of knowledge has followed no fixed course. It has, unlike industry, established no definite pattern of evolution. Some of the great medical discoveries came through the use of elaborate and extensive equipment. Others, equally great, were the achievement of lone workers with almost no equipment. Many searches for new contributions sacrificed their lives in the struggle.

"PROFESSIONAL KNOWLEDGE CAPITAL"

The dominance of the "professional knowledge capital" is of primary importance in the development of any program of furnishing medical service, including hospital care. Unless this immaterial "capital" maintains its dominance over the physical capital in any such program, the service itself suffers. The physical capital must remain the instrument wielded by the personal skill and knowledge.

Notwithstanding this personal element in the practice of medicine, there are certain commercial organizers and promoters and others who, sensing the universal importance of, and necessity for, medical care and utilizing the popular discussion about the *costs* of medical care are developing mass production schemes out of which they may derive a profit. Most of these schemes are too well known to need any description at this time.

MASS PRODUCTION SCHEMES

It is significant that this attempt to capture and commercialize the professions by the use of mass production methods in the marketing of medical and hospital care should appear just when industry and business are endeavoring to incorporate into their methods some of the characteristics of the professions. At the present moment, efforts to "professionalize business are being directed by trade associations, legislation, and a host of semi-public bodies and interested individuals in an effort to restrain some of the excesses of business.

COSTS OF ADMINISTRATION

The claims of organizers and promoters that only those trained in commercial organization and promotion can efficiently and economically market

medical service under these new proposals is entirely unconvincing when one examines similar endeavors abroad. In England there are today between 5,000,000 and 6,000,000 contributors to voluntary hospitalization plans. The cost of administration in these plans varies from 3 to 10 per cent. There are no paid high pressure salesmen who depend upon volume clever sales talks, misrepresentation, underbidding, and perhaps coercion in some instances, for their commissions. Nor is it by any means impossible to cite instances in the United States in which civic and relief projects are being maintained with creditable success by thousands of individuals whose primary motive is not personal financial gain.

The motive which underlies a project is one factor which often insures success or failure. It has never been shown that the introduction of commercialism in medicine accomplishes the highest ideals of the medical profession. On the other hand, commercialism usually means a deterioration of medical services and a disruption of the medical profession; either of these results are inimical to the best interests of the public.

THE CONTROL OF THE PRACTICE OF MEDICINE

Wherever the control of the practice of medicine has been wrested from the medical profession, it is found that either the public or the profession or both are dissatisfied with the result. Conversely, it is found that in those countries where the medical profession retains control of the practice of medicine both the public and the medical profession seem to be satisfied.

WHO ARE THE PROPONENTS OF THE MEDICAL REVOLUTION?

In the mad rush to provide a new method of administering medical care there seems to be an almost entire absence of demand from the working classes for this medical revolution. The worker has for years declared that were he given an adequate living wage he would be able to provide his own needs and services. Most of the schemes proposed by these commercial organizers and promoters, ostensibly for the benefit of the low income group but likewise equally important for the promoter's own selfish monetary advancement, depend upon the small regular payments from this low income group for their success. It should be clear, therefore, that it is the less fortunate class for the most part that is being called upon to contribute the 20 to 75 per cent overhead cost of underwriting administration and profits. Obviously, if 20 to 75 per cent of the poor man's dollar goes for administration and the profits of the money-greedy promoters, this same dollar cannot buy but 25 to 80 per cent of the medical service for the poor man that his money ought to buy. This surely is an economically unsound method of reducing the costs of medical care to the low income groups.

Not only is the person of low income thus deprived of the full value of his dollar, but the medical profession and the hospitals share, to a correspondingly lessened degree, in the available funds collected by these commercial promoters to pay for their services. It should be clear, then, that it is the low income group, the medical profession, and the hospitals that contribute handsomely to the support of these artificial and parasitic medical schemes.

WHAT ANALYSIS OF SOME OF THE PLANS SHOWS

An analysis of the numerous proposals and operating schemes indicates that in most cases the economic principles which apply to the practice of medicine have been wholly disregarded. For example: (1) These commercial conjurers are not concerned over the fact that as the commercial interests secure an increasingly larger portion of the medical market, using only a comparatively small number of physicians to do their work, it becomes increasingly difficult for the physicians in independent private practice to secure enough patients to maintain themselves respectably. Furthermore it will become almost impossible for recent graduates in medicine to establish themselves in practice at all. (2) The disappearance of professional control is of no importance to the promoter; in fact, his scheme is often specifically designed to transfer such control from medical to lay groups. (3) Since he has no understanding of medical traditions, ethics or science, the commercial promoter is unprepared to appreciate quality of medical service, therefore the quality of the medical care, and in some instances the quantity, is reduced to conserve his, the promoter's, funds, since competent medical personnel cost him more than a less competent staff.

WHAT SHALL BE THE NUMBER OF PHYSICIANS

A further problem lies in the fact that, as the number of physicians in the United States increases, professional competition will become more keen. It cannot be stated just what number of physicians will represent the saturation point for physicians' services. Communities vary in their requirements, but with modern conveniences and equipment the same number of physicians are able to serve more people now than ever before. If professional competition is to be prevented from becoming destructive, two alternatives are open—either the number of new physicians licensed annually must be brought more closely to equal the annual loss by death and retirement, or the medical profession must develop greatly, unused fields of preclinical medicine. Certainly economic relief and professional independence for the medical profession cannot be assured by the acceptance of lay promoted commercial schemes.

ECONOMIC QUACKERY

The quack in medical economics sees in every scheme either a panacea or a poison. The scientist studies each new plan as he does a new practice or a new drug to determine its helpful and/or harmful features and how it can be utilized in existing practices and pharmacopeias.

The correct diagnosis and treatment of a medical economic problem should proceed along the same general lines in economics as in medicine. Social problems are often more complex and require no less research than those of other fields, and economics, no more than medicine, can prescribe a panacea for every disease it can diagnose.

It is three hundred years since Galileo originated the experimental scientific method of acquiring knowledge, and whole fields of thought and action still go on as if he had never lived. Economics and politics are only just beginning to follow scientific methods. But during that period of three hundred years even the very limited application of that method has added more to human knowledge and human progress than all the centuries of dogmatic rationalization.

Economic quackery in its relation to medicine flourishes best during periods of social and economic stress. During such periods the tendency to establish unsound and dangerous methods of administering medical care is greatest. It should be obvious, therefore, that all proposals to change medical practice during troublesome times must be subjected to the most searching examination in order that the time-proved principles of medicine shall not be destroyed.

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ANTIVIVISECTION *

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I

THE usual antivivisection bill has been introduced in the legislature, this time under the sponsorship (presumably "by request") of Senator Roy Fellom of San Francisco. It would, the dispatches say, "forbid universities, research laboratories and experimental stations from using animals for experiments or demonstrations of any kind."

This is the regular biennial attack, ostensibly on "cruelty," but actually on science. It has never passed the legislature and would be vetoed if it did. Even the periodic efforts to pass it by initiative have met with decisive defeat. Nevertheless, because the opponents of science are persistent, its defenders must be vigilant.

That the real opposition is to science rather than to "cruelty" is shown by the fact that these bills always authorize the infliction of pain on animals for other purposes, but prohibit scientific experiments even without pain. They all permit branding, dehorning, spaying and gelding on farms, without anesthetic, but forbid opening the vein of a mouse or a guinea pig in the laboratory, even under anesthesia. Most of them would prohibit feeding one rat on wheat and another on corn, to study the comparative processes of digestion. They permit the slaughtering of cattle for food and the poisoning of squirrels for protection, but they would forbid a pin-prick in a rabbit to measure the dose of insulin to save a human life.

The "cruelty" part of the crusade is simply untrue. If the torture tales of current antivivisection pamphlets were correct, then every university president in the United States, every dean of every medical school and every doctor you personally know would be a liar. These are the men to whom we have entrusted the guidance of our youth and the safeguarding of our lives. If they were men who would solemnly lie to the world, on a matter of which they have personal knowledge and cannot be honestly mistaken, that would be worse than the "tortures" of which they are accused. Better close our colleges than have our sons and daughters corrupted by such men, and better die untreated than permit ourselves to be operated on by a surgeon who would lie about an operation on a dog. Instead, these are the very men whom we trust above all others.

The antiscience attack is the more insidious because fewer people are equipped to check its statements. The allegation is that animal experiments have added nothing to human knowledge, anyway. But careful reading will usually disclose that the real meaning is that there is no such knowledge to add to. It is impossible to deny that animal experiments discovered antitoxin and insulin, but it is possible to question whether these were worth discovering. Nobody who knows the facts, to be sure, does question it; but there are many who do not know the facts. It is possible to think that it is right to make soup of the flesh of slaughtered cattle, but wicked to make adrenalin of their glands. Absurd as it seems, some persons do think just that.

So let us get two things straight:

First, "vivisection" is not torture.

Very few laboratory experiments involve cutting, and these are done under an anesthetic, whenever it would be used in operations on human beings. This writer has had done to himself, with and without an anesthetic, practically every surgical thing that is done to animals in laboratories—the last one five minutes before this paragraph was written. And we have all inflicted on rats, to get rid of them, worse suffering than they ever undergo in laboratories.

Most laboratory experiments are medical, not surgical, and involve no more discomfort to the animals than the same diseases do to men. If one sick rabbit will save a thousand sick babies, is not that worth while?

And, second, the real opposition is to science. In a democracy men have that right. A man need not believe that quinin kills malaria or that vaccination prevents smallpox. He may even think that strychnin is not poison. But he must not, on that belief, administer it to others. Neither should he have the power, because he does not know that antitoxin cures diphtheria, to forbid the pin-pricks in horses and guinea pigs, required for production of antitoxin and the measurement of its dosage.

The democratic right not to know the truth does not alter the fact that it is the truth. The laws of nature still operate, whether you "believe in" them or not. Nobody who recognizes the existence of medical knowledge doubts that animal ex-

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* See also editorial comment in this issue, page 379.